

# **State of Indiana**

# **MITA 2.0 Assessment**

# **Standard**

**Family and Social Services**  
**Administration**  
**Office of Medicaid Policy and Planning**

**Indiana MITA Assessment Project**  
**4TG WBS Reference 2.0 (OMPP Deliverable 2.4.2)**

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## Revision History

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The following table records the revision history of this document.

Version	Date	Author	Comments
1.0	03/26/08	Bostick/Miller/Makishima	Original Draft
2.0	04/11/08	Miller	Incorporate OMPP Comments.

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## Executive Summary

The Indiana Family and Social Services Administration (FSSA), Office of Medicaid Policy and Planning (OMPP) contracted with FourThought Group (4TG) to facilitate, assist, and conduct a MITA State Self Assessment. This project, known as the Indiana MITA Assessment Project includes the following major milestones:

- ▶ Document Indiana Medicaid Enterprise Goals and Objectives for the next 5-10 years.
- ▶ Align the Indiana FSSA/OMPP Business Process Model with the MITA Business Process Model/Assessment Standard to facilitate conducting the State Self Assessment (SSA)
- ▶ Conduct and document a Current Capabilities (As Is) assessment of the current Indiana Medicaid Enterprise
- ▶ Conduct and document a Target Capabilities (To Be) assessment for the Indiana Medicaid Enterprise.
- ▶ Create a Transition and Implementation plan to document a recommended process and list of priority projects for moving from the Current State to the Future State.

This MITA Assessment Standard Deliverable is the first step in conducting a MITA State Self Assessment (SSA) for the State of Indiana. The MITA SSA is now a critical component of the Advanced Planning Document (APD) process CMS requires for states to receive enhanced federal funding for system improvement initiatives. 4TG developed the approach to this task in compliance with the Centers for Medicare and Medicaid Services (CMS) Medicaid Information Technology Architecture (MITA) Framework 2.0 and tailored the approach to the unique structure of the Indiana Medicaid Enterprise, as described and defined by key Indiana executives in the planning and initiation phase of the project.

CMS defines MITA as a framework that provides a blueprint to be used by states as they implement enterprise solutions. Indiana shares the basic goals and objectives of MITA and is using the tenets of the MITA principles as it takes the steps necessary to develop seamless and integrated systems that effectively communicate together allowing the technical and business environments to be supportive and responsive to new initiatives and programs. Indiana's vision, as articulated in the Project Charter, also intends to bring the Indiana Medicaid Enterprise into alignment with MITA and other healthcare initiatives.

The MITA Assessment Standard/Alignment task defines the business processes of Indiana's Medicaid Enterprise and determines at a high-level how they map to the MITA Business Process Model. The alignment activity provides the foundation for conducting a Medicaid Enterprise MITA State Self Assessment as it identifies

all processes performed by all organizational or functional units that support Indiana's Medicaid program and maps those process to the MITA 2.0 Model. In this way, it accounts for the unique structure in Indiana and serves to validate Indiana's concurrence with MITA goals and objectives.

The FSSA/OMPP Business Process Model, shown in Appendix B, presents each Indiana Medicaid business process area and business process resulting in a reference model that represents Indiana's unique organization. The MITA 2.0 to FSSA/OMPP Business Process Model Crosswalk, shown in Appendix C, aligns each of Indiana's business areas and processes with MITA 2.0 providing a crosswalk between the FSSA/OMPP Business Process Model (Appendix B) and the MITA 2.0 Business Process Model (Appendix A). This mapping document provides a foundation for Indiana to use in reporting the results of the MITA SSA to CMS, as displayed in Template 3 of the MITA Framework 2.0, Appendix E. This comprehensive analysis positions us to move seamlessly to the next major MITA milestone, the development of the Indiana Current (As Is) Assessment.

## Purpose

Administration of the Medicaid Program officially falls under the authority of OMPP. However, because of the Memoranda of Understanding (MOU) between OMPP and other Divisions/Departments within FSSA, actual administration of the program broad and occurs within several departments and divisions included in FSSA.

The purpose of this MITA 2.0 Assessment Standard deliverable is to provide FSSA/OMPP with a reliable, valid business capability maturity standard. This document describes the processes and methods undertaken by 4TG staff to review, analyze, decompose and tailor the broad MITA 2.0 architecture framework. This effort results in a MITA Assessment reference model or standard which will serve as the basis for the Indiana MITA Assessment.

Medicaid is a federal-state health care program that covers acute and long term health care services for 56 million low income or disabled Americans. Distinct from many federal programs, Medicaid is administered by states based on federal regulations and a State Plan. Thus, in the words of the U.S. General Accounting Office, "Medicaid consists of more than 50 distinct 'state' programs."

Accordingly, models developed at the federal level for use by state Medicaid programs are typically broad and generic and must be tailored to fit the unique circumstances of each state. As an initial step in the MITA Assessment process, 4TG completes this tailoring step to create a relevant Assessment Standard. This deliverable focuses on describing the process of standardizing the MITA 2.0 model, and tailoring the model to create a valid Indiana FSSA/OMPP Assessment Standard.

Specifically, this document describes the steps in decomposing the MITA 2.0 model; the process to review the Indiana organization and the process to align the Indiana business areas and processes with the MITA business areas and processes.

This identification of business areas and alignment of business processes results in a reference model that is tailored to the distinct program and unique organizational needs of FSSA/OMPP. The MITA 2.0 Indiana FSSA/OMPP Assessment Standard is the conceptual model representing the MITA business areas, processes and capabilities, which are then used to assess the enterprise's current (As Is) and target (To Be) capability maturity levels.

## **Background**

MITA is modeled on other widely recognized capability maturity models, such as Software Engineering Institute's (SEI) Capability Maturity Model® Integration (CMMI). These models provide a process improvement approach for organizations by detailing the essential elements of effective processes. Capability maturity models can be used to guide process improvement in a project, a department, or across an entire enterprise. Additionally, these models can be used to assess current maturity, target future levels and determine the gaps between the two levels. An organization, like FSSA/OMPP can use a capability model, like MITA to:

- ▶ Align traditionally separate organizational functions
- ▶ Construct a point of reference to assess current process capability maturity
- ▶ Identify process improvement targets
- ▶ Identify quality improvement targets

The MITA Maturity Model's (MMM) five capability levels represents a progression of maturity of quality improvement benchmarks for business, technical and health management best practices for Medicaid programs. These benchmarks and best practices were identified and defined as part of CMS's MITA initiative. The purpose of the MITA Maturity Model is to provide guidance for improving overall effectiveness of government health care business processes, with emphasis on a Medicaid Enterprise.

## **Methodology**

MITA Framework 2.0 provides more than 980 pages of documentation providing general guidance and direction for the states' use of this capability maturity model. This model can be used as a toolset for organizational alignment and health care business process improvement consistent with an emerging national model. The information is intentionally broad to enable states to align their business processes using a national standard, yet meet their unique state needs and goals for operating and managing the Medicaid Enterprise.

It provides the opportunity for states to align their organizations and operations with relevant portions of this national model to assess current capabilities and target a path for improvement. This is particularly important as it relates to the design, development and implementation of supporting technology systems, since it provides a clear path for the business need to drive technology decisions. Like the Federal Enterprise Architecture model, the MITA process starts with the program or business defining its needs and envisioned future. The MITA assessment process provides a structured national framework; 4TG has analyzed and standardized this framework to establish a measurable model and then tailored this model for the unique Indiana Medicaid Enterprise. The purpose of the MITA Assessment is to enable a state to chart its progression of capability maturity to improved organizational effectiveness and health outcomes, and to align its business and technological resources to achieve its vision, mission and capability improvements.

State Medicaid organizations and enterprises use the maturity level approach to achieve progressive improvements in their performance maturity. Benefits of this approach include:

- ▶ Providing a proven sequence of improvements, beginning with basic management practices and progressing through a predefined and proven path of successive levels, each serving as a foundation for the next,
- ▶ Permitting comparisons across and among organizations by the use of maturity levels,
- ▶ Supporting the MITA transition planning approach for the development of future systems,
- ▶ Providing a single rating that summarizes assessment results allowing comparisons among enterprises.

### **Maturity Assessment Tracking Toolset (MATT)**

To assist States in conducting a MITA Assessment, 4TG developed the Maturity Assessment Tracking Toolset (MATT). MATT is a web-application tool which enables an organization to assess, within the MITA framework, its capability maturity across varying times and levels to target a path for improvement. The MITA 2.0 business maturity model includes a set of capabilities defined as progressive levels of business process maturity.

Strategic goals, such as those in Indiana, are most often achieved over long periods of time, often several years. For this project, MATT supports Indiana's need to measure and track its progress toward achieving this defined set of long-term, strategic goals. At the conclusion of the project, the data gathered in the MATT tool will be exported to an Excel spreadsheet or similar application for future use by Indiana.

### **Research and Data Gathering**

A document request was presented to OMPP in the early stages of the project. The document request listed various types of documents that typically can provide the framework and organization of the Medicaid Enterprise in any given State. Indiana DTS staff acted as the single point of collection for this documentation, reaching out to various FSSA/OMPP staff to determine existing documentation that met 4TG's request. These documents were then loaded for review on the Indiana MITA Assessment Sharepoint site.

## Terminology

This document contains a number of terms which have different meanings depending on how they are used. In an effort to assist FSSA/OMPP in fully understanding the document, 4TG has identified these terms and defined them below:

- ▶ **Enterprise** – this term is synonymous with the Medicaid Enterprise and is used interchangeably in this document. The Medicaid Enterprise includes the business processes and systems that are directly related to the administration and operation of the Medicaid Program in the State of Indiana
- ▶ **MITA Assessment** – this term is synonymous with MITA State Self Assessment and is used interchangeably in this document.
- ▶ **FSSA/OMPP Business Model** – this term is synonymous with Indiana Business Model and is used interchangeably in this document.

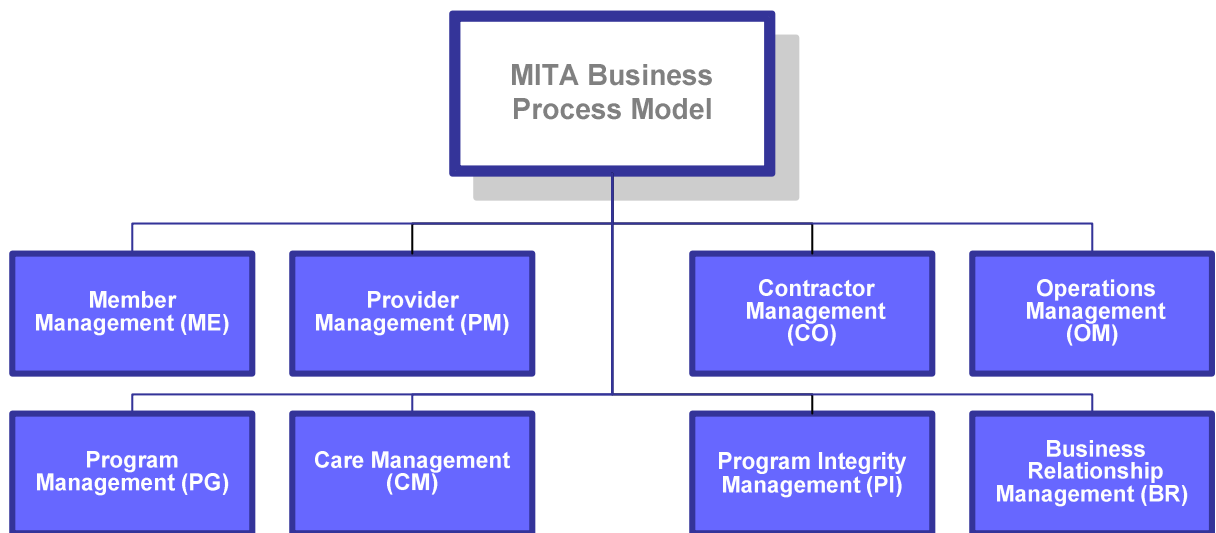
## Findings

### Overview

This deliverable is a synthesis of information from MITA 2.0 and from FSSA/OMPP to create a measurable and tailored MITA Assessment Standard based on the MITA Framework 2.0. MITA 2.0 was much more complete than 1.0, but it was still lacking consistency and there were many gaps in the data. The development of the MITA 2.0 model and the Assessment Standard help to bridge these gaps and create a reliable tool to assess the state Medicaid Enterprise. The tool provides a framework for examining the Medicaid business and identifying potential aspects for improvement.

### Analysis of MITA 2.0

The MITA 2.0 Business Architecture has 8 Business Areas and 79 Business Processes, based on the CMS reference materials.



**Figure 1 MITA Business Process Model**

Although the business areas and processes were clear as structured in MITA 2.0, there were inconsistencies in the listing of these between the MITA 2.0 narrative and appendices materials. Differences in how the model was structured from one section to another created challenges in analyzing and decomposing the MITA 2.0 model. To stay true to the MITA 2.0 intent, analysis techniques were used to overcome these challenges creating clarity, consistency, and configuration resulting in model integrity, transferability and accuracy of the MITA 2.0 Assessment.

## MITA Maturity Matrix

The 4TG MMM Evaluation Matrix is the source matrix for 4TG MITA Assessments. This matrix uses the MITA first-level business process areas and enhances the information with definitions to assist the user in determining the business functionality and processes that should be considered during the assessment. It also incorporates definitions for the five MITA maturity levels.

As the CMS MITA documentation evolves, 4TG will continue to update the MMM Evaluation matrix. As stated earlier, the MITA 2.0 published documentation is generic enough to fit any Medicaid Enterprise situation, and must be tailored for each state Medicaid Enterprise. Thus in decomposing the model to develop an Assessment Standard, 4TG had to define the business capabilities, characteristics and measures at each MITA maturity level. The exhibit below, "MITA Maturity Matrix Elements" defines the elements that comprise the maturity model.

**Table 1 Elements contained in the MITA Maturity Matrix**

MITA MATURITY MATRIX ELEMENTS	
	DEFINITION
CAPABILITY	A capability is the ability to execute a specified course of

MITA MATURITY MATRIX ELEMENTS	
	DEFINITION
	action. To achieve a capability an enterprise must have: desire, ability, and commitment. For each business process, there is at least one capability. Capabilities answer the question of “what” needs to be performed and measured. In the business view, 4TG recognized the need to identify capabilities that required technical support in order to be accomplished. For example, specific types of reference data should optimally be updated by the end-user rather than updated through programming staff changes to system logic and/or code. The business view does not define how to accomplish this requirement, but this need is more appropriately classified as a technical capability which must be supported by the Medicaid Management Information System (MMIS). The model supports the ability to identify either business or technical capabilities.
CHARACTERISTIC	Characteristics further define capabilities. Characteristics elaborate the traits that a capability should exhibit to further define the maturity level at which the capability is performed. Some characteristics are timeliness, effort to perform, cost-effectiveness, and utility to stakeholders. Just like a capability, the model supports the ability to classify a business or technical characteristic.
MEASURE	For each characteristic, there is at least one measure. The measures are designed to allow a simple yes/no confirmation of whether the capability exhibits the pertinent characteristic. A yes-response indicates that an enterprise exhibits or exceeds the desired trait. To meet all the criteria for a particular capability level, the enterprise must answer yes to all measures for every characteristic related to that capability level. Additionally, all measures are classified as business or technical based on the classification of the corresponding characteristic.

## Capabilities

All of the capabilities, whether or not listed in the narrative and in the appendices of 2.0, were included in the review. Within the MITA framework, the definition of a capability for a specific business process changes with each maturity level. Some capabilities were described in detail, while others were presented at a very high level of business. The alignment of the matrix structure required significant consideration to ensure model integrity and flexibility. We provided additional definition to the capability definitions and completed a second analysis of the documentation, the result being the final MITA 2.0 Business Process Model shown in Appendix A of this document.

## Characteristics

The MITA 2.0 Business Process Model presented several challenges in developing consistent and measurable capabilities. The technical dependencies needed to be removed in order to ensure an accurate assessment of business capabilities. Because the MITA 2.0 Model has yet to complete characteristics for all of the capabilities defined in the model, it was not possible to create a complete model

from the MITA Framework documentation. For measurement to be valid and reliable, measurement needed to be determined on only one axis. Applying the six characteristics in MITA 2.0 to all of the 79 business processes, 4TG developed a valid and reliable MITA Assessment Standard with characteristics listed in the columns and the Levels of Maturity listed in rows. The Business Area and Process sections of this MITA Assessment Standard are presented in Appendix A.

## Maturity Levels

**Table 2 MITA 2.0 Maturity Levels**

<b>LEVEL 1</b>	Agency focuses on meeting compliance thresholds for state and Federal regulations, aiming primarily at accurate enrollment of program eligibles and timely and accurate payment of claims for appropriate services.
<b>LEVEL 2</b>	Agency focuses on cost management and improving the quality of and access to care within structures designed to manage costs (e.g., managed care, catastrophic care management, and disease management).
<b>LEVEL 3</b>	Agency focuses on coordination and collaborating with other agencies to adopt national standards and develop and share reusable business processes to improve the cost effectiveness of healthcare services delivery. Agency promotes intrastate data exchange.
<b>LEVEL 4</b>	Agency, now with widespread and secure access to clinical data, can improve healthcare outcomes, empower beneficiaries and provider stakeholders, measure objectives quantitatively, and focus on program improvement.
<b>LEVEL 5</b>	Agency can now focus on fine tuning and optimizing program management, planning, and evaluation, with national (and international) interoperability improvements that maximize automation of routine operations.

## Six Characteristic Types

Each general description of a level is supplemented by more specific definitions in a set of qualities or characteristics. The following six characteristics represent aspects of capabilities that are measurable:

- ▶ Timeliness of Process
- ▶ Data Access and Timeliness
- ▶ Effort to Perform; Efficiency
- ▶ Cost-Effectiveness
- ▶ Accuracy of Process Results
- ▶ Utility to Stakeholders

Among the challenges of using these levels in the MITA assessment is that each Level is measured in a different way. For instance:

- ▶ Level 1: Agency focuses on meeting compliance thresholds for state and Federal regulations, aiming primarily at accurate enrollment of program eligibles and timely and accurate payment of claims for appropriate services.

- ▶ Level 2: Agency focuses on cost management and improving the quality of and access to care within structures designed to manage costs (e.g., managed care, catastrophic care management, and disease management).

Consistently following the model requires each level of maturity to have a different description for each capability to identify the maturity level, increasing the complexity of characteristics application and consistency in measurement. To establish a valid and reliable model, we used the five levels of maturity as a guide to create the measures in the matrix to indicate how a business would progress through the different levels.

### **Measures**

As we refined the characteristics and maturity levels in the new model, the measures were used as the intersection of the characteristics and the maturity levels. 4TG refined the MITA model documentation to establish a set of consistent, reliable measures for characteristics and maturity levels. This not only improved the measurability, but also the progression and steps needed to move from one maturity level to the next.

### **Tailoring MITA Capabilities to Indiana Medicaid's Business**

For the MITA maturity model to be useful, each organization must review and tailor the MITA maturity model to its own situation. With that in mind, 4TG developed this deliverable to ensure that the MITA model represents how business is done in Indiana without omission of any Indiana business processes.

In order to align the Indiana Medicaid Enterprise with MITA and to develop the Assessment Standard that will be used, 4TG first obtained a thorough understanding of the Indiana Medicaid Enterprise and the organization that supports this enterprise. 4TG completed this task by analyzing the documentation provided by the State during project initiation, reviewing existing documentation including Indiana website notices, State Plan documents, policy manuals, and other documentation. The analysis also resulted in the development of the Indiana FSSA/OMPP Business Process Model.

### **Indiana Medicaid Enterprise and Organization**

The State of Indiana performs and supports Medicaid business processes across much of the Family and Social Services Administration (FSSA). The Indiana Medicaid Program operates an 1115(b) waiver and several 1915(c) waivers for a majority of the Indiana Medicaid Program. The major components of the Indiana Medicaid program include the following:

- ▶ Home and Community Based waivers – Indiana Medicaid offers five home and community based waivers to members of the Indiana Medicaid program. These include:
  - ◆ Aged and Disabled Waiver
  - ◆ Autism

- ◆ Traumatic Brain Injury (TBI)
- ◆ Developmental Disability
- ◆ Support Services

The Aged and Disabled Waiver and the TBI waiver are administered by the Division of Aging. The Autism, Developmental Disability and Support Services waivers are administered by the Division of Disability and Rehabilitative Services (DDRS). All of these waivers are administered with assistance from and oversight by OMPP. These waivers were created to address specialized health care needs for persons who would be institutionalized in the absence of these community based services.

- ▶ Healthy Indiana Plan (HIP) - This new initiative provides health insurance for uninsured adult Hoosiers between 19-64 whose household income is between 22% and 200% of the federal poverty level (FPL) and who are not eligible for Medicaid. Eligible participants must be uninsured for at least six (6) months and cannot be eligible for employer-sponsored health insurance. HIP is not an entitlement program (such as Medicaid) and enrollment is limited based upon available funding. Eligibility for the program is on a first come first serve basis. A key cornerstone of the program is the Personal Wellness Responsibility (POWER) account, which is similar to a Health Savings Account (HSA). Participants will contribute a monthly amount to their POWER account according to a sliding scaled based on their income. The State will subsidize the account to ensure that there is a total of \$1,100 available in the account initially. The program provides a basic commercial benefits package for participants once annual medical costs for the participant exceed \$1,100. Enrollment in the program (assuming contributions are made timely by the participant) is for 12 months at which time the participant must re-certify. The State contracts with commercial insurance carriers to provide coverage for the HIP program.
- ▶ Hoosier HealthWise – This 1115(b) waiver is a mandatory managed care program also referred to as Risk Based Managed Care (RBMC). The program covers low income families, children and pregnant women. The CHIP program is included in the Hoosier Healthwise program, but operates outside of the 1115(b) waiver requirements. The program is administered via the State's contracted Managed Care Organizations (MCOs). Hoosier Healthwise provides coverage for parents and children who receive Temporary Assistance for Needy Families (TANF) and for low income, pregnant women and children. There are four (4) member benefit packages associated with the program as listed below:
  - ◆ Package A – Standard Plan
  - ◆ Package B – Pregnancy Coverage Only
  - ◆ Package C – Children's Health Insurance Plan (CHIP)
  - ◆ Package E – Emergency Services Only (in FFS only)

- ▶ Traditional Medicaid – Traditional Medicaid provides coverage for health care services rendered to the following eligibility groups:

- ◆ Wards and foster children who do not voluntarily enroll in a managed care program (Note: this population will move to the Care Select Program in Summer 2008)
- ◆ Persons in nursing homes and other institutions such as ICF/MR facilities
- ◆ Undocumented aliens
- ◆ Waiver or hospice services
- ◆ Spenddown recipients

Eligible members receive health care services from enrolled IHCP providers. Services rendered to Traditional Medicaid recipients are processed as Fee for Service (FFS) by the OMPP MMIS claims processing contractor. A large portion of this population are “dual eligible” for both Medicaid and Medicare leading to issues with coordination and integration of data and care management of this population.

- ▶ Medicaid Select – This program was added to the existing 1915(b) waiver to include the aged, blind and disabled populations. The program is managed by the State’s enrollment broker. The program is being replaced by the Care Select program.
- ▶ Care Select – The State of Indiana has created a care management program known as Care Select, to serve the aged, blind and disabled populations. This program is managed by entities known as Care Management Organizations (CMO’s). The Care Select program is replacing the Medicaid Select Program in a phased in approach with a projected completion of total transition by January 01, 2009.
- ▶ M.E.D Works – The State of Indiana operates a work incentive program known as M.E.D Works or Medicaid for Employees with Disabilities. The program is Indiana’s Medicaid Buy-In program for working people with disabilities. To be eligible for M.E.D Works, individuals must:
  - Be 16-64
  - Meet Indiana Medicaid income and resource guidelines
  - Meet Indiana Medicaid definition of disability irregardless of their employment status

Most M.E.D Works members are already enrolled in Medicaid. Based on an individual’s income, the person may pay a Medicaid premium to receive coverage. Individuals enrolled in M.E.D Works have the same coverage for services and co-payments as individuals enrolled in regular Medicaid.

OMPP is the single state agency responsible to CMS for oversight of the Indiana Medicaid Program.

Other stakeholders in the Indiana Medicaid Enterprise, who administer programs on behalf of Indiana Medicaid, include the following:

- ▶ Division of Mental Health and Addiction (DMHA) – ensures the availability of accessible, acceptable, and effective mental health and substance abuse related disorder services for Indiana residents. Also responsible for providing funding support for mental health and addiction services to target populations with financial need through a network of managed care providers, certifying all community mental health centers and managed providers, and administering Federal funding associated with substance abuse prevention projects.
- ▶ Division of Disability and Rehabilitative Services (DDRS) – manages aging and in-home services, guardianship, and adult protective services, and determines medical eligibility for the Supplemental Security Income (SSI) and Social Security Disability (SSD) programs for the Federal Government. The Division also provides case management services for persons with developmental disabilities, including supervision services for four developmental centers for clients with disabilities, operation of several State institutions, vocational rehabilitation case management services, independent living services for the deaf and hard of hearing, and services for the blind and visually impaired.
- ▶ Division of Family Resources (DFR) – is responsible for determining eligibility for Indiana Health Coverage Programs for services under Indiana Medicaid.
- ▶ Division of Aging (DA) – provides institutionalized nursing home services to older adults. DA is working with local communities to begin to move the population it serves from nursing homes into appropriate community based settings. One of the primary goals for DA is to move services to the community, with the assistance of local organizations, to provide the appropriate services to individuals and their families.
- ▶ Indiana State Department of Health (ISDH) – provides a multitude of services and programs to both Medicaid and non-Medicaid clients. Of primary focus for the Medicaid population are Newborn Screening, Lead Screening, Asthma, HIV services, and Immunization services.

### **Indiana FSSA/OMPP Business Process Model**

With a thorough understanding of the Indiana Medicaid Enterprise and the organizational units that support this enterprise, FourThought Group analyzed the documentation provided by the State during project initiation. FourThought Group gathered and organized detailed information about the business processes used to support Indiana's Medicaid program and developed the Indiana FSSA/OMPP business process model that is presented in Appendix B.

### **MITA and Indiana FSSA/OMPP Alignment**

The alignment of the MITA 2.0 Standard to the Indiana FSSA/OMPP business process model was the activity that mapped each model's business areas and processes. In this activity, the MITA Assessment Standard from Appendix A is utilized in its entirety. The Indiana FSSA/OMPP business areas and processes (contained in Appendix B) are then placed beside the appropriate MITA business area/process combination to determine Indiana's alignment with the MITA Standard. Appendix C presents the alignment results of the MITA standard and the FSSA/OMPP business process model, thus establishing the Indiana FSSA/OMPP Assessment Standard. This Indiana FSSA/OMPP Assessment Standard provides the guide for future MITA SSA activities such as the MITA Current Capability (As Is) and Target Capability (To Be) assessments and will assist the State in meeting the MITA APD reporting requirements set forth the MITA Framework 2.0, Appendix E, Template 3.

## **Analysis of Indiana Business Processes not addressed by MITA**

Based on FourThought Group's analysis, the Indiana FSSA/OMPP Business Process Model aligns tightly to the MITA standard. The analysis confirmed that all processes presented in MITA are currently performed by Indiana's Medicaid Enterprise. For this reason, the Indiana FSSA/OMPP MITA Assessment activities will be conducted using the MITA 2.0 Standard.

## **Conclusions**

FourThought Group has detailed the process, methodology and results of analyzing the MITA Framework 2.0 business process model to create the MITA 2.0 Assessment Standard.

As previously described, the CMS MITA 2.0 materials provide an important national framework of emerging documentation to assist state Medicaid enterprises in conducting a MITA Assessment that, in its current state of development, is not yet a measurable model for the complete Medicaid enterprise. 4TG has worked to decompose the capabilities, characteristics and measures, and reconstruct the MITA model into a valid and reliable assessment tool. Additionally, 4TG reviewed the Indiana FSSA/OMPP processes and practices found in existing FSSA/OMPP documentation to create the Indiana FSSA/OMPP business process model. Finally, this Indiana FSSA/OMPP business model was aligned to the MITA 2.0 Assessment Standard to confirm that Indiana performs all business processes currently defined in MITA 2.0.

The MITA Assessment Standard is only an initial step in the assessment process. It provides the measurement tool to determine both the Current (As Is) and Target (To Be) business capabilities and the framework for creating a quality Transition and Implementation plan.



## Appendix A – MITA 2.0 Assessment Standard

Area	Process
<b>Business Relationship Management</b>	
	Establish Business Relationship
	Manage Business Relationship
	Manage Business Relationship Communication
	Terminate Business Relationship
<b>Care Management</b>	
	Establish Case
	Manage Case
	Manage Medicaid Population Health
	Manage Registry
<b>Contractor Management</b>	
	Administrative Contracting (Enrollment Brokers, QRO, FI, FA, etc.) - Award Administrative Contract
	Administrative Contracting (Enrollment Brokers, QRO, FI, FA, etc.) - Close-Out Administrative Contract
	Administrative Contracting (Enrollment Brokers, QRO, FI, FA, etc.) - Manage Administrative Contract
	Contractor Information Management - Inquire Contractor Information
	Contractor Information Management - Manage Contractor Information
	Contractor Support - Manage Contractor Communication
	Contractor Support - Perform Potential Contractor Outreach
	Contractor Support - Support Contractor Grievance and Appeal
	Health Services Contracting (PCCM, PCP, MCO, PBM, etc.) - Award Health Services Contract
	Health Services Contracting (PCCM, PCP, MCO, PBM, etc.) - Close-Out Health Services Contract
	Health Services Contracting (PCCM, PCP, MCO, PBM, etc.) - Manage Health Services Contract
<b>Member Management</b>	
	Eligibility Determination - Determine Eligibility
	Enrollment - Disenroll Member
	Enrollment - Enroll Member
	Member Information Management - Inquire Member Eligibility
	Member Information Management - Manage Member Information
	Prospective and Current Member Support - Manage Applicant and Member Communication
	Prospective and Current Member Support - Manage Member Grievance and Appeal
	Prospective and Current Member Support - Perform Population and Member Outreach
<b>Operations Management</b>	

Area	Process
	OM1 - Service Authorization - Authorize Referral
	OM1 - Service Authorization - Authorize Service
	OM1 - Service Authorization - Authorize Treatment Plan
	OM2 - Claims/Encounter Adjudication - Apply Claim Attachment
	OM2 - Claims/Encounter Adjudication - Apply Mass Adjustment
	OM2 - Claims/Encounter Adjudication - Audit Claim/Encounter
	OM2 - Claims/Encounter Adjudication - Edit Claim/Encounter
	OM2 - Claims/Encounter Adjudication - Price Claim/Value Encounter
	OM3 - Payment and Reporting - Prepare Coordination of Benefits (COB)
	OM3 - Payment and Reporting - Prepare Explanation of Benefits (EOB)
	OM3 - Payment and Reporting - Prepare Home and Community-Based Services (HCBS) Payment
	OM3 - Payment and Reporting - Prepare Premium EFT/Check
	OM3 - Payment and Reporting - Prepare Provider EFT/Check
	OM3 - Payment and Reporting - Prepare Remittance Advice/Encounter Report
	OM4 - Capitation and Premium Preparation - Prepare Capitation Premium Payment
	OM4 - Capitation and Premium Preparation - Prepare Health Insurance Premium Payment
	OM4 - Capitation and Premium Preparation - Prepare Medicare Premium Payment
	OM5 - Payment Information Management - Inquire Payment Status
	OM5 - Payment Information Management - Manage Payment Information
	OM6 - Member Payment Management - Calculate Spend-Down Amount
	OM6 - Member Payment Management - Prepare Member Premium Invoice
	OM7 - Cost Recoveries - Manage Drug Rebate
	OM7 - Cost Recoveries - Manage Estate Recovery
	OM7 - Cost Recoveries - Manage Recoupment
	OM7 - Cost Recoveries - Manage Settlement
	OM7 - Cost Recoveries - Manage TPL Recovery
<b>Program Integrity Management</b>	
	Identify Candidate Case
	Manage Case
<b>Program Management</b>	
	Accounting - Manage 1099s
	Accounting - Perform Accounting Functions
	Benefit Administration - Designate Approved Services/Drug Formulary
	Benefit Administration - Develop and Maintain Benefit Package
	Benefit Administration - Manage Rate Setting
	Budget - Formulate Budget

Area	Process
	Budget - Manage Federal Financial Participation for MMIS
	Budget - Manage Federal Medical Assistance Percentages (F-MAP)
	Budget - Manage State Funds
	Program Administration - Develop Agency Goals and Initiatives
	Program Administration - Develop and Maintain Program Policy
	Program Administration - Maintain State Plan
	Program Information - Generate Financial & Program Analysis/Report
	Program Information - Maintain Benefit/Reference Information
	Program Information - Manage Program Information
	Program Quality Management - Develop and Manage Performance Measures and Reporting
	Program Quality Management - Monitor Performance and Business Activity
<b>Provider Management</b>	
	Provider Enrollment - Disenroll Provider
	Provider Enrollment - Enroll Provider
	Provider Information Management - Inquire Provider Information
	Provider Information Management - Manage Provider Information
	Provider Support - Manage Provider Communication
	Provider Support - Manage Provider Grievance and Appeal
	Provider Support - Perform Provider Outreach

## Appendix B – Indiana FSSA/OMPP Business Process Model

Area	Process
<b>Business Relationship Management</b>	
	Establish Business Relationship
	Manage Business Relationship
	Manage Business Relationship Communication
	Terminate Business Relationship
<b>Care Management</b>	
	Establish Case
	Manage Case
	Manage Medicaid Population Health
	Manage Registry
<b>Contractor Management</b>	
	Administrative Contracting (Enrollment Brokers, QRO, FI, FA, etc.) - Award Administrative Contract
	Administrative Contracting (Enrollment Brokers, QRO, FI, FA, etc.) - Close-Out Administrative Contract
	Administrative Contracting (Enrollment Brokers, QRO, FI, FA, etc.) - Manage Administrative Contract
	Contractor Information Management - Inquire Contractor Information
	Contractor Information Management - Manage Contractor Information
	Contractor Support - Manage Contractor Communication
	Contractor Support - Perform Potential Contractor Outreach
	Contractor Support - Support Contractor Grievance and Appeal
	Health Services Contracting (PCCM, PCP, MCO, PBM, etc.) - Award Health Services Contract
	Health Services Contracting (PCCM, PCP, MCO, PBM, etc.) - Close-Out Health Services Contract
	Health Services Contracting (PCCM, PCP, MCO, PBM, etc.) - Manage Health Services Contract
<b>Member Management</b>	
	Eligibility Determination - Determine Eligibility
	Enrollment - Disenroll Member
	Enrollment - Enroll Member
	Member Information Management - Inquire Member Eligibility
	Member Information Management - Manage Member Information
	Prospective and Current Member Support - Manage Applicant and Member Communication
	Prospective and Current Member Support - Manage Member Grievance and Appeal
	Prospective and Current Member Support - Perform Population and Member Outreach
<b>Operations Management</b>	

Area	Process
	OM1 - Service Authorization - Authorize Referral
	OM1 - Service Authorization - Authorize Service
	OM1 - Service Authorization - Authorize Treatment Plan
	OM2 - Claims/Encounter Adjudication - Apply Claim Attachment
	OM2 - Claims/Encounter Adjudication - Apply Mass Adjustment
	OM2 - Claims/Encounter Adjudication - Audit Claim/Encounter
	OM2 - Claims/Encounter Adjudication - Edit Claim/Encounter
	OM2 - Claims/Encounter Adjudication - Price Claim/Value Encounter
	OM3 - Payment and Reporting - Prepare Coordination of Benefits (COB)
	OM3 - Payment and Reporting - Prepare Explanation of Benefits (EOB)
	OM3 - Payment and Reporting - Prepare Home and Community-Based Services (HCBS) Payment
	OM3 - Payment and Reporting - Prepare Premium EFT/Check
	OM3 - Payment and Reporting - Prepare Provider EFT/Check
	OM3 - Payment and Reporting - Prepare Remittance Advice/Encounter Report
	OM4 - Capitation and Premium Preparation - Prepare Capitation Premium Payment
	OM4 - Capitation and Premium Preparation - Prepare Health Insurance Premium Payment
	OM4 - Capitation and Premium Preparation - Prepare Medicare Buy-In Premium Payment
	OM5 - Payment Information Management - Inquire Payment Status
	OM5 - Payment Information Management - Manage Payment Information
	OM6 - Member Payment Management - Calculate Spend-Down Amount
	OM6 - Member Payment Management - Prepare Member Premium Invoice
	OM7 - Cost Recoveries - Manage Drug Rebate
	OM7 - Cost Recoveries - Manage Estate Recovery
	OM7 - Cost Recoveries - Manage Recoupment
	OM7 - Cost Recoveries - Manage Settlement
	OM7 - Cost Recoveries - Manage TPL Recovery
<b>Program Integrity Management</b>	
	Identify Candidate Case
	Manage Case
<b>Program Management</b>	
	Accounting - Manage 1099s
	Accounting - Perform Accounting Functions
	Benefit Administration - Designate Approved Services/Drug Formulary
	Benefit Administration - Develop and Maintain Benefit Package
	Benefit Administration - Manage Rate Setting
	Budget - Formulate Budget

Area	Process
	Budget - Manage Federal Financial Participation for MMIS
	Budget - Manage Federal Medical Assistance Percentages (F-MAP)
	Budget - Manage State Funds
	Program Administration - Develop Agency Goals and Initiatives
	Program Administration - Develop and Maintain Program Policy
	Program Administration - Maintain State Plan
	Program Information - Generate Financial & Program Analysis/Report
	Program Information - Maintain Benefit/Reference Information
	Program Information - Manage Program Information
	Program Quality Management - Develop and Manage Performance Measures and Reporting
	Program Quality Management - Monitor Performance and Business Activity
<b>Provider Management</b>	
	Provider Enrollment - Disenroll Provider
	Provider Enrollment - Enroll Provider
	Provider Information Management - Inquire Provider Information
	Provider Information Management - Manage Provider Information
	Provider Support - Manage Provider Communication
	Provider Support - Manage Provider Grievance and Appeal
	Provider Support - Perform Provider Outreach

## Appendix C – MITA 2.0 to Indiana FSSA/OMPP Mapping

MITA Assessment Standard		Indiana Business Process Model	
Area	Process	Area	Process
<b>Business Relationship Management</b>		<b>Business Relationship Management</b>	
	Establish Business Relationship		Establish Business Relationship
	Manage Business Relationship		Manage Business Relationship
	Manage Business Relationship Communication		Manage Business Relationship Communication
	Terminate Business Relationship		Terminate Business Relationship
<b>Care Management</b>		<b>Care Management</b>	
	Establish Case		Establish Case
	Manage Case		Manage Case
	Manage Medicaid Population Health		Manage Medicaid Population Health
	Manage Registry		Manage Registry
<b>Contractor Management</b>		<b>Contractor Management</b>	
	Administrative Contracting (Enrollment Brokers, QRO, FI, FA, etc.) - Award Administrative Contract		Administrative Contracting (Enrollment Brokers, QRO, FI, FA, etc.) - Award Administrative Contract
	Administrative Contracting (Enrollment Brokers, QRO, FI, FA, etc.) - Close-Out Administrative Contract		Administrative Contracting (Enrollment Brokers, QRO, FI, FA, etc.) - Close-Out Administrative Contract
	Administrative Contracting (Enrollment Brokers, QRO, FI, FA, etc.) - Manage Administrative Contract		Administrative Contracting (Enrollment Brokers, QRO, FI, FA, etc.) - Manage Administrative Contract
	Contractor Information Management - Inquire Contractor Information		Contractor Information Management - Inquire Contractor Information
	Contractor Information Management - Manage Contractor Information		Contractor Information Management - Manage Contractor Information
	Contractor Support - Manage Contractor Communication		Contractor Support - Manage Contractor Communication
	Contractor Support - Perform Potential Contractor Outreach		Contractor Support - Perform Potential

MITA Assessment Standard		Indiana Business Process Model	
			Contractor Outreach
	Contractor Support - Support Contractor Grievance and Appeal		Contractor Support - Support Contractor Grievance and Appeal
	Health Services Contracting (PCCM, PCP, MCO, PBM, etc.) - Award Health Services Contract		Health Services Contracting (PCCM, PCP, MCO, PBM, etc.) - Award Health Services Contract
	Health Services Contracting (PCCM, PCP, MCO, PBM, etc.) - Close-Out Health Services Contract		Health Services Contracting (PCCM, PCP, MCO, PBM, etc.) - Close-Out Health Services Contract
	Health Services Contracting (PCCM, PCP, MCO, PBM, etc.) - Manage Health Services Contract		Health Services Contracting (PCCM, PCP, MCO, PBM, etc.) - Manage Health Services Contract
<b>Member Management</b>		<b>Member Management</b>	
	Eligibility Determination - Determine Eligibility		Eligibility Determination - Determine Eligibility
	Enrollment - Disenroll Member		Enrollment - Disenroll Member
	Enrollment - Enroll Member		Enrollment - Enroll Member
	Member Information Management - Inquire Member Eligibility		Member Information Management - Inquire Member Eligibility
	Member Information Management - Manage Member Information		Member Information Management - Manage Member Information
	Prospective and Current Member Support - Manage Applicant and Member Communication		Prospective and Current Member Support - Manage Applicant and Member Communication
	Prospective and Current Member Support - Manage Member Grievance and Appeal		Prospective and Current Member Support - Manage Member Grievance and Appeal
	Prospective and Current Member Support - Perform Population and Member Outreach		Prospective and Current Member Support - Perform Population and Member Outreach
<b>Operations Management</b>		<b>Operations Management</b>	
	OM1 - Service Authorization - Authorize Referral		OM1 - Service Authorization - Authorize Referral
	OM1 - Service Authorization - Authorize Service		OM1 - Service Authorization - Authorize Service
	OM1 - Service Authorization - Authorize Treatment Plan		OM1 - Service Authorization - Authorize Treatment Plan
	OM2 - Claims/Encounter Adjudication - Apply Claim		OM2 - Claims/Encounter Adjudication - Apply Claim

<b>MITA Assessment Standard</b>		<b>Indiana Business Process Model</b>	
	Attachment		Attachment
	OM2 - Claims/Encounter Adjudication - Apply Mass Adjustment		OM2 - Claims/Encounter Adjudication - Apply Mass Adjustment
	OM2 - Claims/Encounter Adjudication - Audit Claim/Encounter		OM2 - Claims/Encounter Adjudication - Audit Claim/Encounter
	OM2 - Claims/Encounter Adjudication - Edit Claim/Encounter		OM2 - Claims/Encounter Adjudication - Edit Claim/Encounter
	OM2 - Claims/Encounter Adjudication - Price Claim/Value Encounter		OM2 - Claims/Encounter Adjudication - Price Claim/Value Encounter
	OM3 - Payment and Reporting - Prepare Coordination of Benefits (COB)		OM3 - Payment and Reporting - Prepare Coordination of Benefits (COB)
	OM3 - Payment and Reporting - Prepare Explanation of Benefits (EOB)		OM3 - Payment and Reporting - Prepare Explanation of Benefits (EOB)
	OM3 - Payment and Reporting - Prepare Home and Community-Based Services (HCBS) Payment		OM3 - Payment and Reporting - Prepare Home and Community-Based Services (HCBS) Payment
	OM3 - Payment and Reporting - Prepare Premium EFT/Check		OM3 - Payment and Reporting - Prepare Premium EFT/Check
	OM3 - Payment and Reporting - Prepare Provider EFT/Check		OM3 - Payment and Reporting - Prepare Provider EFT/Check
	OM3 - Payment and Reporting - Prepare Remittance Advice/Encounter Report		OM3 - Payment and Reporting - Prepare Remittance Advice/Encounter Report
	OM4 - Capitation and Premium Preparation - Prepare Capitation Premium Payment		OM4 - Capitation and Premium Preparation - Prepare Capitation Premium Payment
	OM4 - Capitation and Premium Preparation - Prepare Health Insurance Premium Payment		OM4 - Capitation and Premium Preparation - Prepare Health Insurance Premium Payment
	OM4 - Capitation and Premium Preparation - Prepare Medicare Premium Payment		OM4 - Capitation and Premium Preparation - Prepare Medicare Buy-In Premium Payment
	OM5 - Payment Information Management - Inquire Payment Status		OM5 - Payment Information Management - Inquire Payment Status
	OM5 - Payment Information		OM5 - Payment Information

MITA Assessment Standard		Indiana Business Process Model	
	Management - Manage Payment Information		Management - Manage Payment Information
	OM6 - Member Payment Management - Calculate Spend-Down Amount		OM6 - Member Payment Management - Calculate Spend-Down Amount
	OM6 - Member Payment Management - Prepare Member Premium Invoice		OM6 - Member Payment Management - Prepare Member Premium Invoice
	OM7 - Cost Recoveries - Manage Drug Rebate		OM7 - Cost Recoveries - Manage Drug Rebate
	OM7 - Cost Recoveries - Manage Estate Recovery		OM7 - Cost Recoveries - Manage Estate Recovery
	OM7 - Cost Recoveries - Manage Recoupment		OM7 - Cost Recoveries - Manage Recoupment
	OM7 - Cost Recoveries - Manage Settlement		OM7 - Cost Recoveries - Manage Settlement
	OM7 - Cost Recoveries - Manage TPL Recovery		OM7 - Cost Recoveries - Manage TPL Recovery
<b>Program Integrity Management</b>		<b>Program Integrity Management</b>	
	Identify Candidate Case		Identify Candidate Case
	Manage Case		Manage Case
<b>Program Management</b>		<b>Program Management</b>	
	Accounting - Manage 1099s		Accounting - Manage 1099s
	Accounting - Perform Accounting Functions		Accounting - Perform Accounting Functions
	Benefit Administration - Designate Approved Services/Drug Formulary		Benefit Administration - Designate Approved Services/Drug Formulary
	Benefit Administration - Develop and Maintain Benefit Package		Benefit Administration - Develop and Maintain Benefit Package
	Benefit Administration - Manage Rate Setting		Benefit Administration - Manage Rate Setting
	Budget - Formulate Budget		Budget - Formulate Budget
	Budget - Manage Federal Financial Participation for MMIS		Budget - Manage Federal Financial Participation for MMIS
	Budget - Manage Federal Medical Assistance Percentages (F-MAP)		Budget - Manage Federal Medical Assistance Percentages (F-MAP)
	Budget - Manage State Funds		Budget - Manage State Funds
	Program Administration - Develop Agency Goals and Initiatives		Program Administration - Develop Agency Goals and Initiatives
	Program Administration - Develop and Maintain Program Policy		Program Administration - Develop and Maintain Program Policy

MITA Assessment Standard		Indiana Business Process Model	
	Program Administration - Maintain State Plan		Program Administration - Maintain State Plan
	Program Information - Generate Financial & Program Analysis/Report		Program Information - Generate Financial & Program Analysis/Report
	Program Information - Maintain Benefit/Reference Information		Program Information - Maintain Benefit/Reference Information
	Program Information - Manage Program Information		Program Information - Manage Program Information
	Program Quality Management - Develop and Manage Performance Measures and Reporting		Program Quality Management - Develop and Manage Performance Measures and Reporting
	Program Quality Management - Monitor Performance and Business Activity		Program Quality Management - Monitor Performance and Business Activity
<b>Provider Management</b>		<b>Provider Management</b>	
	Provider Enrollment - Disenroll Provider		Provider Enrollment - Disenroll Provider
	Provider Enrollment - Enroll Provider		Provider Enrollment - Enroll Provider
	Provider Information Management - Inquire Provider Information		Provider Information Management - Inquire Provider Information
	Provider Information Management - Manage Provider Information		Provider Information Management - Manage Provider Information
	Provider Support - Manage Provider Communication		Provider Support - Manage Provider Communication
	Provider Support - Manage Provider Grievance and Appeal		Provider Support - Manage Provider Grievance and Appeal
	Provider Support - Perform Provider Outreach		Provider Support - Perform Provider Outreach